

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

5505

594

1. PLACE OF DEATH

County Jackson
Township Wheatley
City Kansas City

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME Amanda Lawson

(a) Residence. No. 1607 Harrison St. H Ward _____

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF James Lawson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug II 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 5 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife at Home
(b) General nature of industry, business, or establishment in which employed (or employer) 2
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Arkansas
(STATE OR COUNTRY) _____

10. NAME OF FATHER Bob Goodwin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Arkansas
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

14. INFORMANT James Lawson
(Address) 1607 Harrison, St.

15. FILED 2/8 31 M.M. Conroy
1931 REGISTRAR
Wren

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 5th. 1931

17. I HEREBY CERTIFY That I attended deceased from Jan 27 1931 to Feb 5 1931 that I last saw him alive on Feb 5 1931 and that death occurred, on the date stated above, at 2:45 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis of Brain
(Small intestine)
355
27B
operation for Pus tubes of
uterus (duration) yrs. mos. ds. 6 ds.
CONTRIBUTORY (SECONDARY) uterus (duration) yrs. mos. ds. 6 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF 1-31-31
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS none
(Signed) Dr. Miller M. D.

2-7 1931 (Address) Kansas City, Mo

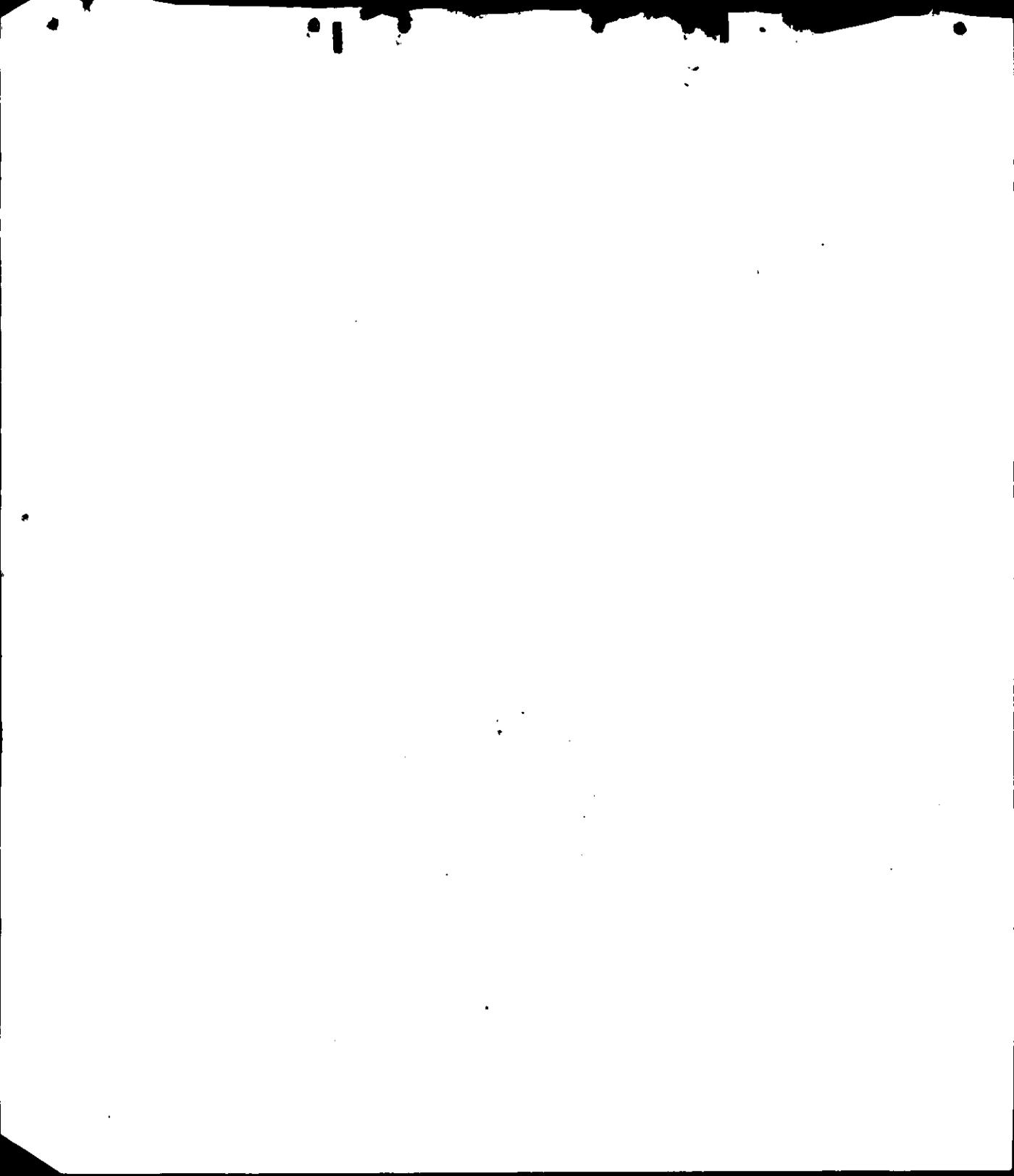
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland Cemetary, DATE OF BURIAL Feb, 9th, 31

20. UNDERTAKER West, Appleton & Jones . ADDRESS K.C. Mo.

RESERVED FOR BINDING
WHITE PLAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



caused by check marks, lacking from the death certificate:

Name:

Amanda Lawson

Who died at:

Kansas City, Mo. Feb. 5, 1931

Residence: No. _____

St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred:

Years _____ Months _____ Days _____

Sex: _____

Color or race: _____

Single, married, widowed or divorced: _____

Date of birth: _____

Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____

(b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH:

Paralysis of Ileum

(Small Intestines)

Contributory:

Operation for Pus tubes of Uterus. Unsuccessful

Where was disease contracted? _____

Did operation precede death? _____

Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

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